

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2025
NAME OF PROVIDER OR SUPPLIER  Waters of Lebanon, The		STREET ADDRESS, CITY, STATE, ZIP CODE  1585 Perry Worth Rd Lebanon, IN 46052	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow safety guidelines and to provide adequate employee training resulting in a resident's wheelchair falling over during transport in a facility vehicle for 1 of 3 residents reviewed for accidents (Resident B). Findings include: On 7/30/25 at 3:20 p.m., Resident B was observed lying on the bed watching television. The bed was positioned against the wall lower to the floor and a small manual wheelchair was sitting beside the top of the bed. The resident indicated, the prior week while she was being driven to her dialysis appointment in the facility van, her wheelchair tipped over and she fell hitting her head on the floor. The van was being driven by a maintenance staff worker, not the facility's primary transportation driver. Resident B indicated she was not sure exactly what happened, but she did not think she had been properly secured in the van because when they turned a corner she fell. The resident indicated she had pain on one side of her body after the fall and was subsequently seen in the emergency room (ER) of a nearby hospital. Resident B's clinical record was reviewed on 7/30/25 at 2:00 p.m. Resident B who was admitted on [DATE] had diagnoses to include end stage renal disease (ESRD - kidney failure), difficulty walking, and dependence on renal dialysis.admission Minimum Data Set (MDS) assessments, completed on 7/26/25, assessed Resident B as being cognitively intact. The resident was dependent on staff for bed mobility, transfers in and out of bed, and transfers in and out of a car or van. The resident used a manual wheelchair for mobility. An incident report, dated 7/26/25 at 6:50 a.m., documented Resident B as having had a fall. Physician's orders for Resident B included, a. Dialysis weekly on Monday, Wednesday, and Friday. b. Apixaban (Eliquis - a blood thinner) 2.5 milligrams (mg) give 1 tablet by mouth daily.An electronic notification to providers, dated 7/26/25 at 6:50 a.m., indicated Resident B had fallen. An examination of the resident indicated she was currently taking an anticoagulant medication, was complaining of pain after the fall, and one pupil was restricted. The primary provider responded with a recommendation to send the resident to the ER for testing and x-rays. A nursing progress note, dated 7/26/25 at 8:36 a.m., indicated Resident B had an unwitnessed fall while being transported to dialysis. The resident's wheelchair fell backwards, and the resident fell flat on her back and head. The resident returned to the facility where she was assessed and found to have right pupil constriction and complaints of head and right arm pain. Resident B was sent out to the ER. An interdisciplinary team (IDT) progress note, dated 7/28/25 at 9:09 a.m., indicated Resident B had an unwitnessed fall during transport to a dialysis appointment. The resident fell backward in a wheelchair during transport, and Registered Nurse (RN) 11 who had been following the van pulled over and assessed the resident, who said she was sore. Upon return to the facility, Resident B complained of pain in her shoulder, and she was sent to the ER for evaluation. A local hospital report, dated 7/26/25, indicated Resident B who was taking Eliquis presented to the ER after a mechanical fall experience while on her way to dialysis. The resident was getting in the van and had a mechanical fall, and she stated she hit her head and her right arm. The resident complained of having a mild headache but severe right arm pain that was constant non-radiating and was worse with touch and movement. Computed tomography (CT) scans of the head, and x-rays of the right shoulder and right elbow were performed. A care plan written for Resident B after her fall on 7/26/25, indicated the resident was at risk of falls related to general weakness, and difficulty walking. Interventions included ensuring placement of seatbelts during transportation by facility staff and provide education to staff who transported the resident to outside appointments. A transportation van education sign-in sheet, dated 6/20/25, indicated 6 employees had been educated on the correct operation of a van lift, correct procedure for loading/unloading a resident on a lift, correct procedure for securing a resident with the proper tie downs, and manual operation of a van lift. Maintenance Worker 11 signed as having received the education. The facility lacked documentation the 6 employees who were providing resident transport with the facility van had been observed for competence, or that the employees had been re-educated regarding safety protocols after the incident that had occurred on the van 6/20/25.During an interview on 7/31/25 at 9:44 a.m., the Director of Nursing (DON) indicated Resident B had been admitted to the facility with orders for dialysis at a local dialysis center three times a week, and she was being transported in the facility van. On 7/26/25 while enroute to dialysis, Resident B's wheelchair tipped backwards, and the resident fell resulting in pain to her shoulder and head. Maintenance Worker 11 later indicated at the time of the incident, the front belt was off the wheelchair. The DON indicated, to her knowledge, there was nothing mechanically wrong with the van. During an interview on 7/31/25 at 10:10 a.m.</p>		